Bulletin of Anomalous Experience

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Editorial

BAE in 1994 and Beyond

I am delighted with the way BAE has grown in the last two years. And, from your calls and letters, many of you feel this publication continues to be of service. I am therefore pleased to announce that I intend to continue this project through 1994.

The focus of BAE in 1994 and beyond will continue to be the medical and psychotherapeutic aspects of UFOs, the UFO abduction and contact phenomena. BAE will continue to study the following questions:

- What is the cause (or causes) of abduction and contact experiences?
- How can we better distinguish truly anomalous cases from unusual (but not paranormal) physiological and psychological phenomena, from pathology, and from other paranormal phenomena?
- How do these experiences affect people?
- How can the helping professions best serve experiencers?

We will continue to include material on the broad range of paranormal and anomalous experiences with an emphasis on how they relate to UFOs. Regular readers know that I interpret this pretty broadly to include material from the disciplines of medicine, psychiatry, psychology, parapsychology, anthropology, sociology, folklore, and more.

The usual plea for contributions

BAE exists to serve as a meeting place for the "invisible college", a place for professionals from a variety of disciplines to present their ideas and experiences, discuss and debate, and point out emerging trends. For the newsletter to continue to flourish, I need your contributions. Your comments on the contents of each issue are always welcome (indeed, expected!). In addition, consider one of the following ways of contributing material to BAE in 1994:

- a page or two about your clinical or professional experiences in the field over the last year(s)
- a case study (see last issue for one of mine as an example)
- research questions you would like to see addressed
- an article about a particular issue of interest to you relevant to this field.

Additionally, send me articles you come across in your reading that would be of interest to BAE readers. This is especially important for those in the folklore, sociology and anthropology fields, because I don't have as much exposure to that literature.

Increasing the readership base

The more professionals who read BAE, the more discussion can be stimulated and sustained, and the more BAE can be of service to professionals, experiencers, and interested lay people alike. So, one objective for the next year is to increase the number of professionals subscribing to BAE (particularly physicians, psychologists and other licensed therapists, but also parapsychologists, anthropologists, sociologists, folklorists, etc.). If you know of such colleagues who might be interested in participating or simply following the discussions, please show them a copy of BAE. If you want some additional copies to pass around, let me know and I will supply them.

Interested experiencers and lay people are also welcome to subscribe and to encourage others to subscribe. The "Experiencers' Section" allows experiencers to keep us scientist-types grounded, and gives them a place to tell us how the people we are researching and treating feel about what we are doing. And I hope that the information and discussion in BAE provides lay readers with some solid grounded education about the complexities of abduction studies.

Happy reading. Let me know what you think of this issue.

David

Mail

on the Accuracy of Recall

I am enclosing a few news items, including some detailed reporting on a very recent daughters vs father alleged sexual molestation case based on the daughters' childhood memories *[summarized in "False Memory Syndrome: In The Courts," later in this issue]*. The outcome leaves me with a queasy feeling, primarily because it seems to have been decided basically by lawyers! (Though I don't have much more faith in "hired gun" courtroom psychologists).

This is a truly sticky case, but even granting that the story is filtered through reporters (they seem to do a responsible job) I thought he probably was guilty in this case. With the prevailing double standards, I wonder if a woman could ever get justice. What we all need to address is, how can reasonably objective and scientific methods be brought to bear for determining the truth about such cases "beyond a reasonable doubt." I refer to empirical research, not to more "theorizing" that often seems to be only an attempt to justify the theorizer's preconceptions.

The possibility for rank injustices to occur in the courtrooms seems to be very high, so that scorecards on legal outcomes would be a poor guide for trying to figure out lessons for abduction case memories. At present, the only potential solution I can see is (a) increased research on memory recall and post-traumatic stress disorder under conditions applicable to childhood sexual molestation and childhood abduction recall cases; and (b) careful documentation of medical/physical/observational evidence that the person recalling childhood abduction experiences probably is having accurate recall.

I'm not sure whether it would be possible to prove a negative in this case, but certainly investigators also should look for any evidence suggesting an alternative explanation for the childhood abduction memories. Again, I refer to evidence, not to air castle theories designed to justify a foregone conclusion.

Richard Hall

Contribution and Subscription Information

Bulletin of Anomalous Experience is a networking newsletter about the UFO abduction phenomenon and related issues, for mental health professionals and interested scientists.

BAE is a forum for presentation of ideas and information, and debate of same. Thus, contributions are encouraged. Comments on anything you see here, brief or lengthy and detailed; articles from the literature you think are relevant to this field; notices of books or journals; opinion pieces. Write!

Our editorial policy was best described by Hilary Evans, who said we try to "comfortably tread the narrow path between the groves of academia and the dust and heat of the marketplace, inquiring and suggesting, not asserting or insisting."

Subscriptions are $25 per calendar year (6 bimonthly issues); back issues are also available at $25 per calendar year. Remit in U.S. funds for U.S. and foreign orders, and Canadian funds for Canadian orders. Make checks or money orders payable to "David Gotlib, M.D."

Send contributions to BAE, or requests for subscriptions, to

David Gotlib, M.D.
Bulletin of Anomalous Experience
2 St. Clair Avenue West, Suite 607
Toronto, Ontario, Canada M4V 1L5
Telephone (416) 963-8700
Fax (416) 962-4622
CompuServe 72037,737
Well "drdave"

Networking

Parapsychology Foundation Counseling Bureau

c/o Parapsychology Foundation, Inc.
228 E 71st Street, New York NY 10021
Telephone 212-628-1550, FAX 212-628-1559

(the following is from their press release)

Prompted by an increase in requests by the public for qualified counselors and clinicians who are familiar with issues pertaining to parapsychology and psi phenomena, the Parapsychology Foundation (see below) is establishing the Parapsychology Foundation Counseling Bureau. By virtue of Parapsychology Foundation's longtime position in the field, working as an international clearing house for parapsychological information, we are very often asked by individuals and organizations for licensed professionals capable of dealing with people who report experiences involving possible psi components. It is our opinion that such a bureau would be a great benefit to the general public.

Areas of interest include the entire spectrum of paranormal phenomena, including apparitions, hauntings, possession, psychic "assault," and abduction reports.

There is no cost for this service. Licensed therapists wishing to be listed in their database should send the following information to the address above:

- Name
- Credentials
- License number and state(s) where you practice
(a copy of license must be included with registration form)
- Address; Phone and/or fax number(s)
- Areas of expertise
- Payment requirements, if any
- Other information

Parapsychology Foundation, Inc.

(the following is from their brochure)

The Parapsychology Foundation was established in 1951 to encourage and support impartial scientific inquiry into the psychical aspects of human nature. Eileen J. Garrett, the founder, was noted for her pioneering work in psychical research. A participant in some of the landmark experiments of the 1920s and 1930s, she recognized that psychical research was ignored by a large segment of the academic community. She knew that practical aid for scholars and scientists working in this area, now known as parapsychology, would not be available from most universities or other foundations. The best scientists might thus be lost to parapsychology through lack of essential resources.

The Parapsychology Foundation, as envisioned by Eileen J. Garrett, would therefore encourage scientific investigators to pursue independent studies of the human mind. Scientists and scholars from many disciplines would now bring to the laboratory and the classroom new concepts of the psychical elements in man. The Foundation is not a membership organization nor does it maintain a laboratory or a research division. It observes objectively the many research and theoretical studies of parapsychology, and offers assistance to scientists and universities engaged in the interdisciplinary approach to a better understanding of telepathy, clairvoyance, precognition, psychokinesis and other psychic phenomena.

Library
The Eileen J. Garrett Library, located at the Foundation offices in New York, is one of the world's largest libraries on parapsychology that is open to the public. The facility is for reference use only. The main emphasis is on the literature of contemporary and experimental parapsychology, related subjects (such as altered states of consciousness, hypnosis, dreams) and those publications approaching the subject with objective and/or analytical points of view. The library also maintains a strong collection on the history of parapsychology (early Spiritualism, mysticism, psychical research and relevant philosophical works) and a rare book collection.

Conferences
The Foundation has since 1951 sponsored domestic and international conferences. For each of these meetings the Foundation selects a parapsychological concept and invites the leading researchers in that particular area to present formal papers on their observations and research and to exchange views on their work with their university and laboratory colleagues at the conference table. Proceedings of these conferences are published in book form by the Foundation.

Publications
Proceedings of International Conferences of the Parapsychology Foundation.
Parapsychological Monographs: A continuing series of research studies, each devoted exclusively to a particular parapsychological proposition.
Guide to Sources of Information on Parapsychology: An introduction to parapsychology and sections on major organizations, education, journals, and books.
Parapsychology Review: The official journal of the Foundation for 20 years. It ceased publication with the March/April 1990 issue. Back issues are still available.

Grant Program
The Parapsychology Foundation considers proposals for original study, research, and experiments on projects concerned with parapsychology.

Parapsychology Sources of Information Center (PSIC)

2 Plane Tree Lane
Dix Hills, NY 11746

I ran a notice for PSIC's semiannual journal EHE (Exceptional Human Experience) in Vol. 4 No. 1. EHE is a valuable resource both for the abstract collection (which complements the abstracts presented in BAE), and the papers on parapsychology. I thought some more information on the Center would complement the previous item about the Parapsychology Foundation.

The Parapsychology Sources of Information Center (PSIC) was founded in 1983 by parapsychologist/librarian Rhea A. White to collect and disseminate information on parapsychology and consciousness studies, especially mystical and unitive states. Since 1989, the PSIC has concentrated on classifying and collecting exceptional human experiences (EHEs) and looking into the possible long-term effect these experiences may have on people's lives, and in particular, their sense of self.

PSIC provides the following services:

PsiLine Database System: A collection of computerized bibliographic databases that emphasize parapsychology and consciousness disciplines. The database includes relevant references to relevant books, articles, theses, technical reports and conference proceedings from a wide variety of disciplines, including philosophy, medicine, religion, psychology, anthropology, sociology, linguistics.

Exceptional Human Experience: A 150-page semiannual journal containing approximately 250 abstracts per issue (from the diverse disciplines catalogued on PsiLine) as well as methodological and theoretical papers.
Directories: PSIC publishes an *International Directory of Persons Granted Degrees for Work in Parapsychology* (434 items), *and Parapsychology Organizations: A Directory* (43 items).
PSIC also publishes bibliographies, books and pamphlets.

Alien Scripture #1

I ran a brief note last issue about this new publication by Kevin McClure (who also produces Wild Places). Since then the first copy has arrived, and I thought BAE readers might appreciate a closer look.

In his introduction Kevin says that
"...*Alien Scripture* will deal with communications that have spiritual content, and events reported as Fortean, UFO, psychic, paranormal, or whatever [but] it will have a more specific purpose. This will be the search for the genuinely otherworldly, for the evidence that, in any culture or context, real, meaningful contact has been made with an intelligence that can be specifically identified as non-human...Such a search might take us anywhere. Certainly there is no limit of time. Contacts of this kind have been claimed for as long as mankind has told stories. We do it now, and no doubt we always will..."

Kevin also promises to look at the boundary between human and divine, by looking both at claims of interactive religious experience (such as visions and charismatic gifts) and at the content of what is said to be communicated 'from God.'

The first issue contains an essay by Martin Kottmeyer examining the ETH from the point of view of the "Problem of Noncontact" (why don't ETs make their presence known openly and clearly?); an article on the struggle in British Spiritualism; another on apparitions of the Virgin Mary; and a piece by Hilary Evans on the Omega Project and the "fantasy-prone personality," and other tidbits.

I enjoyed the first issue of Alien Scripture immensely, and recommend it most highly to BAE readers. AS is published quarterly; subs from the U.S. and Canada are $18 per year; single issues are $5. Pay in cash or by sterling cheque drawn on a British bank. Make payments out to Kevin McClure and send to 24, Victoria Road, Mount Charles, St. Austell, Cornwall, PL25 4QD, England.

Trends

False Memory Syndrome: In The Courts

The debate about FMS and recovered memories of sexual abuse is being fought in the courtroom, as the following news items describe. I discussed the relevance of FMS to anomalous experiences, and abduction experiences in particular, in an editorial in Vol. 4 No. 2 (which has since been reprinted in MUFON UFO Journal and Wild Places). Thanks to Richard Hall and John Colombo for providing the articles.

Some Recent Cases
The Washington Post reported through July and August on the case of a man on trial for molesting his two daughters, ages 12 and 14, ten years previously. The incidents occurred when the parents were separated (they later divorced) during unsupervised visits to the father's apartment. A nasty custody battle was going on at the time.

There was no medical documentation or physical evidence of sexual assault. The defense lawyer did not deny that the children were suffering from emotional problems, but he pointed out that they could not recall anything else that had occurred in their lives during the time in their lives when the alleged molestation occurred. He attributed their emotional problems not to the molestation, but to their mother, whom he suggested coerced the girls into making the allegations. According to the newspaper report, he characterized her "as 'anxious and neurotic,' determined to keep her ex-husband poor and obsessed with child abuse."

The prosecuting attorney dismissed this argument, but had nothing better to offer the jury than the fact that he "believed the girl's testimonies about the alleged abuse were indicative of 'raw, genuine pain. If the 14-year-old who had cried during her testimony had been coached, influenced, or coerced by her mother, the arch-villain as the defendant would like you to believe, do you think she would have had this degree of difficulty in testifying?...Don't you think you would have seen a smoother performance if she had been coached?' "

The father was found not guilty of assaulting the 12-year-old; the jury could not reach a decision on the assault to the 14-year-old.

In August the Washington Post reported on another case: A 45-year-old retired Naval officer on trial for allegedly sexually abusing his daughter, a 19-year-old woman with Multiple Personality Disorder.

The prosecutor, and psychiatrist Richard Loewenstein, director of the dissociative disorders program at Sheppard-Pratt, said the woman's 40-60 different personalities resulted from the trauma of the sexual abuse. "While presenting a single outward persona to the courtroom during her testimony, [the complainant said], she had been internally 'switching from one alter to another. If everybody gets to talk at once, it's just jumbled.' Asked by [the defense attorney] how many alters she'd consulted, she said she had 'no idea.' If a answer could cause her harm, she said, she 'sometimes' might refuse to search for it."

Defense argued that she was sexually abused, but by a neighbour, and attributed the allegations to the "power of suggestion from therapists." Testifying for the defense, Paul McHugh, director of psychiatry at Johns Hopkins University Hospital, said the woman he believed the woman suffers from a "borderline histrionic disorder" induced by therapists. Another psychiatrist retained by the defense testified that she told him that one of her alter egos said to her, "There needs to be a blood sacrifice. Satan will come for me."

The judge declared a mistrial. The jury was unable to reach a unanimous verdict after trying for 8 hours. One juror said all but one or two members of the jury voted for acquittal because the government's case was "too shaky to convict somebody". 3 women shared the majority sentiment

On Expert Witnesses
Another example of how the recovered memory debate is being raged in the courtroom is documented in Once Upon a Time: A True Story of Memory, Murder, and the Law by Harry N. MacLean. The book was reviewed by Paul Buttenwiser in the *New York Times Book Review*, who described the case as follows:

> In 1989, a California woman named Eileen Franklin-Lipsker was watching her daughter play when an innocuous gesture suddenly triggered the mysterious apprehension of something dreadful she had experienced in the remote past. The apprehension rapidly clarified into a vision of a little girl trying to ward off a fatal blow. Mrs. Franklin-Lipsker quickly grasped what it was she was seeing: When she was 9

> years old, a girl from her neighbourhood had been abducted and killed, he head crushed with a rock. No suspect had ever been identified. Now, 20 years later, Mrs. Franklin-Lipsker said she saw the crime re-enacted before her minds eye. Every details was as fresh as if it had all taken place the day before: the little girl, the rock, the murderer...The 8-year-old girl was her best friend. The murderer was her own father.

Mrs. Franklin-Lipsker was the only witness against her father in the murder trial that followed. Her memories of her father murdering the girl were uncorroborated. Buttenwiser had the following to say about the expert psychiatrists and psychologists who testified about whether Franklin-Lipsker's memories should be believed:

> The expert witnesses in the Eileen Franklin case were all, as it happens, serious and dedicated professionals of the very highest integrity. But they, too, could not resist couching their speculations in language like "this memory must be true" or "this memory must be false," covered only by the thinnest veneer of hypothetical disclaimer. As Mr. MacLean...points out, their effectiveness with the jury probably had more to do with their charisma than with their science. In the last analysis, the least educated juror was fully as qualified to guess what was going on in Eileen Franklin's mind as the most expert witness money could buy.
>
> ...The current epidemic of newly remembered sexual abuse has given [expert psychiatrists and psychologists] a tremendous boost. It has brought into the legal system the raging debate about trauma and repression and multiple personality disorder and recovered memories and false memories, a debate that has polarized specialists into bitterly opposing camps. Which hasn't prevented anyone with a credential and an ax to grind from hurrying into the courtroom to describe, under oath, his pet conception of mental functioning, as if it were established scientific fact.

FMS and Civil Suits
The Toronto Star of August 29, 1993 reported on a trend for survivors suing the non-abusing parent for negligence and trying to recover under a homeowner's insurance policy.

"The strategy has been increasingly employed in the United States, with several huge awards, including one $500 million claim, paid out by insurance companies....Because home-owner policies do not cover intentional criminal acts, the abuser cannot be sued. The other parent, almost always the mother, can be, *if* it's proved that she knew, or ought to have known, what was going on...

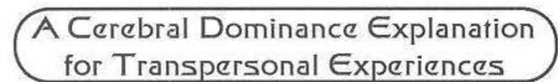
"[London, Ont. lawyer Mark Lerner says],'You would then, however, have to show she failed to do anything about it. Then, that the measures she could have taken would have been effective. Home-owner's insurance covers this failure to 'notice and prevent.'... "California, where most of the claims against insurers have been upheld, recently halted the strategy in its tracks. The state Supreme Court recently rules that sexual assault can never be 'negligent,' and therefore, insurers cannot be liable."

This article cites lawyer Susan Vella as saying FMS "is a political lobby organized to counter the growing number of civil lawsuits...'Those in the false-memory movement criticize 'over-zealous' therapists and 'greedy' lawyers for creating a sexual abuse industry. Well, the only people I see carving out a niche for themselves are the false-memory lobbyists who are running about behind defense witnesses despite the utter absence of scientific backup."

Elizabeth Loftus
from ***You Must Remember This... Or Do You? How Real Are Repressed Memories?,*** *Washington Post June 27, 1993*

> The point is that we do not yet have the tools for reliably distinguishing the signal of true repressed memories from the noise of false ones. Until we gain these tools, it seems prudent to urge care in how horrors on the other side of some presumed amnesic barrier are probed. Is this discriminatory against truly victimized people? I don't think so. For uncritical acceptance of every single claim of sexual abuse, now matter how dubious, is bound to have an unintended and tragic consequence; trivializing the true and ruthless cases of abuse and increasing the suffering of genuine victims.

Original Articles



A Cerebral Dominance Explanation for Transpersonal Experiences

by David Ritchey, Ph.D.
Dr. Ritchey is a certified hypnotherapist with a clinical practice in Brattleboro, Vermont.

"Spiritual Emergencies", those transpersonal experiences which are most likely to come to a clinician's attention don't just happen to anybody. Indications are that there is a certain personality type which is especially prone to having transpersonal experiences — a personality type which has been labeled by Wilson and Barber (1983) as the "Fantasy Prone Personality." While not necessarily pathologizing those who have these experiences, this label certainly has pejorative connotations and seems to dismiss the possibility of there being any ontological validity to the experiences themselves.

Kenneth Ring (1992) offers us the alternative label of "psychological Sensitives" and argues that these people, while not more prone to fantasy, posses a greater than normal sensitivity to the existence of alternate realities. His position is that transpersonal experiences, while correlated with certain neurological and psychological differences, are not *caused by* those differences, but are, rather, *permitted by* them. These experiences, he argues, occur in alternate realities which possess ontological validity, but can only be apprehended from certain alternate states of consciousness, and the ability to enter those alternate states of consciousness is neurologically based. I agree wholeheartedly with Ring's position, and my intention here is to follow his line of reasoning into an examination of those neurological and psychological factors which seem to facilitate these experiences.

The ability to enter alternate states of consciousness is correlated with what Tellegren and Atkinson (1974) call "psychological absorption." Psychological absorption is "total" attention that fully engages all of one's representational resources. It results in a heightened sense of the reality of the attentional object, imperviousness to distracting events, and an altered sense of reality in general. Josephine Hilgard (1965) calls psychological absorption "imaginative involvement" and states that it is the personality factor which correlates with hypnosis (an alternate state of consciousness). Ernest Hilgard (1965) makes an effective case for a dissociative model of hypnosis, and we can see that to the extent one's attention is focused on a specific stimulus, it is dissociated from other irrelevant stimuli. It is this focused attention with its attendant dissociation that permits highly hypnotizable

individuals, those whom Spiegel and Spiegel (1978) call "Grade 5 Subjects" to age regress in the present tense, have total amnesia for the hypnotic experience, and respond to post-hypnotic suggestions for positive hallucinations, negative hallucinations, or motor paralysis. It is also, I suggest, the mechanism which underlies all transpersonal experiences.

Those who are capable of psychological absorption and who are highly hypnotizable are able to create for themselves vivid internal imagery which is subjectively as real as physical stimuli in external reality and may, therefore, sometimes experience difficulty in differentiating imagery as an internal event from perception as an internal representation of an external event. This confusion of an internally generating stimulus with a physical stimulus, known as the "Perky Effect" for a classic experiment in perception conducted by the psychologist C.W. Perky in 1910 (Baker, 1992), is the stuff that "hallucinations" are made of. Because those who are capable of psychological absorption and facile at entering alternate states of consciousness are also capable of creating hallucinations, there has been a tendency to pathologize their perceptions and dismiss their transpersonal experiences as hallucinatory. It is worth noting, however, that hallucinations are defined as "perceptions that occur in the absence of corresponding stimuli in external [consensual] reality" (Asaad, 1990) and the possible existence of alternate realities is precluded by the definition itself — that is, if a perception doesn't originate in consensual reality, then it is, by definition, an hallucination and, therefore, all experiences of alternate realities and all alternate realities themselves are also, by definition, hallucinations.
Ring's (1992) argument, with which I agree, is that the either/or distinction between "reality" and "fantasy" (or "hallucination") is too simplistic and that there exists a third realm, the *imaginal realm*, which is something that is *objectively self-existent*, which is the cumulative product of imaginative thought itself. This realm is the realm of transpersonal experiences and, as I have already indicated, is apprehended only from alternate states of consciousness. Whether or not this conclusion is valid, however, is not particularly relevant to clinicians working with those who are having spiritual emergencies. What is important, I believe, is that these transpersonal experiences be accepted as having a significant degree of subjective reality for the client and that those neuropsychological factors likely to be involved be understood.

Of the several writers who have explored the psychological make-up of those included to have transpersonal experiences, I have already spoken of Wilson and Barber (1983) and their "Fantasy Prone Personality", Spiegel and Spiegel (1978) and their "Grade 5 Hypnotic Subject", Tellegren and Atkinson (1974) and their individuals capable of "psychological absorption", and Kenneth Ring (1992) and his "psychological Sensitives". Mention should also be made of Ernest Hartmann (191) and his "thin boundary" individuals and Michael Persinger (Ring, 1992) and his people with "temporal lobe lability." Among the common characteristics of experiencers which stand out intense studies are: a heightened sensitivity to environmental stimuli such as bright lights, loud noises, crowds, humidity, etc.; a tendency toward sensory overloading and sensory synesthesias; an unusual sensitivity to the effects of electromagnetic fields; a heightened responsiveness to the effects of drugs; a history of auto-immune and other immune system disorders; low levels of brain serotonin; EEG brain-wave patterns involving elevated alpha and theta and depressed beta; a proneness to temporal lobe epilepsy; a history of abuse and/or trauma in childhood; the use of dissociation as a psychological defense mechanism; a high level of hypnotizability; emotional lability; heightened creativity; heightened intuition; and weak gender identity.

My research has led me to believe that what Norman Geschwind (1985) calls "anomalous cerebral dominance" creates the neurological underpinnings for transpersonal experiences and either it or its correlates are responsible for each of the above characteristics. At its simplest level, anomalous cerebral dominance can be defined as an enlargement of the right cerebral hemisphere and/or a diminution of the left such that standard hemispherical asymmetry(with portions of the left hemisphere being larger than their equivalents in the right) cases to exist or is, occasionally, reversed. This elimination of the standard asymmetry permits a greater than normal participation of the right cerebral hemisphere in those functions which are usually under the purview of the left hemisphere —specifically language and motor control of handedness. Greater than normal participation of the right hemisphere in language, Geschwind suggests, can be responsible for both developmental learning disorders and enhanced creativity and intuition because it leads to a more visual and holistic style of cognition, as compared to the logical and sequential style generally associated with standard cerebral dominance. Greater than normal participation of the right hemisphere in motor control for handedness can, of course, lead to left-handedness.

Geschwind's hypothesis is that the primary cause of anomalous hemispheric development is a heightened level of sex hormones, especially testosterone, *in utero*, and, to a lesser extent, in infancy and early childhood. This same heightened level of sex hormones, he states, can cause immune disorders (such as allergies, eczema, ulcerative colitis, insulin dependent diabetes, and lupus erythematosis) by delaying the development of the thymus and other immune system organs. Anomalous cerebral dominance, he says, is also associated with neurological disorders of childhood (such as dyslexia, stuttering, attention deficit disorder, and Tourette's syndrome), neurological disorders of adulthood (such as schizophrenia, certain types of epilepsy, and Alzheimer's disease), birth defects (such as cleft palate, harelip, scoliosis, and wandering eye), chromosomal abnormalities (such as Down's syndrome), and a host of other miscellaneous phenomena such as hypopigmentation, homosexuality, twinning, a lowered life expectancy, sleep disorders, low serotonin levels, and special talents in areas such as music, mathematics, spatial relations, chess, and athletics.

For the purposes of this article, it is the role that anomalous cerebral dominance plays in facilitating entry into alternate states of consciousness that is most important. As I see it, the greater than normal participation of the right cerebral hemisphere in cognition is responsible for enhanced visual thinking, and thus for enhanced potential for psychological absorption, hypnotizability, dissociation, entry into alternate states of consciousness, and ultimately the apprehending of alternate realities. it seems likely that the low brain serotonin levels and the characteristic EEG brain wave patterns, which I have already mentioned as being associated with anomalous cerebral dominance, play a role in this process, as well.
In working with clients who are having spiritual emergencies, being aware of the anomalous cerebral dominance can be useful in helping us to see "the big picture." I always find it helpful to inquire about Geschwind's four primary markers of anomalous cerebral dominance, namely, (1) left-handedness, (2) right-handedness with left-handed first degree relatives (parents, children, siblings), (3) right-handedness with developmental learning disorders, and (4) right-handedness with first degree relatives having developmental learning disorders. Asking about the other correlates listed above, as well, can add additional depth to our understanding of our clients' subjective experiences.

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To Be Or Not To Be: That Is The Question

by Ralph B. Allison, M.D. (With thanks to W. Shakespeare)
Dr. Allison is a California psychiatrist who has dealt with patients, defendants, and inmates with dissociative disorders since 1972.

Much of the debate about the stories told therapists of abduction by UFO's or Satanic Ritual Abuse in families may be the result of difficulties the therapists are having rather than the problems of the patient. Patients approach advertised professional therapists, expecting treatment for what ails them, and the therapists may have difficulty deciding what role to play. Their common choices are Shaman, forensic reporter, or detective. I suggest that it is impossible for one person to play all of these roles with one patient/client/ suspect.

Attempts to do so may have been responsible for much of the debate about whether the patient/client/suspect is telling "the truth." I should know, since I have tried to play all these roles myself, at one time or another, and I now realize the futility of such an unrealistic attempt to be so "flexible" in one's professional life. This is especially true when dealing with certain types of patients.

Most individuals who come for therapy have a degree of inner anxiety that has risen to a level that they can no longer stand. They come for "diagnosis and treatment" to one who has publicly offered to play a helper role to the general public. What the patient needs is a Shaman, someone whom they invite to join them on their shamanic journey. Together, they can explore the world of ideas, emotions, fantasies, and physical discomfort in which the patient resides. Patients are very particular about whom they invite along on such journeys. They need someone who can share their experiences, who can accept what they experience as valid (in contrast to bad, evil, or worthless), and one who has taken sufficient previous similar journeys so that he/she can help the patient make sense out of the trip.

I use the word Shaman as the ancient term to describe the healer the tribe recognized, but today that person may be called doctor, physician, psychotherapist, therapist, psychologist, healer, counselor, guide, support person, etc. When I attended medical school, no professor even mentioned the word "Shaman," and I did not become acquainted with the extensive history of this professional role until I met anthropologists who studied healing methods around the world. Some of them had learned to be Shamans, and they described the shamanic journeys they went on in the "other world" where animal spirits were seen as protectors of them and their patients. Only then did I realize that, during my years of psychotherapy practice with dissociating patients, I had "invented" a number of shamanic techniques. In discussions with these "anthropologists of consciousness," I learned that my "innovative" techniques had been in use for centuries in many cultures around the world. Since no one had never taught me any of these procedures in medical school or psychiatric residency, I thought I was being creative when I "invented" them and used them with dissociating patients.

After my formal psychiatric training, I attended hypnosis classes and Mind Dynamics courses, and I watched rituals performed by a priest who had trained with a Native American medicine man. I also realized I needed to have "symbolic" techniques that transformed mental concepts of my patients into three dimensional reality. I "invented" techniques to assist my patients' progress through their torturous mental journeys. My overriding goal was to bring the patients to a state of improved mental health, so they could lead productive lives in our 20th century environment. That goal had been drilled into me during my medical and psychiatric training.

While going through shamanic journeys, patients told me strange stories about their histories, past lives, family members and significant others. Once, a dissociating patient reported, in hypnosis, that she had killed her stepfather and his two friends after they had attempted to kill her. When she was awake, I informed her what she had told me while in trance. She picked up my phone to call the police and turn herself in.

I asked what evidence she would give the police to demonstrate her guilt for three "murders," as she had described hiding the bodies in distant states and in Canada. After she decided she had nothing physical to prove her "memory" was accurate, she put down the phone. As her mother was her only financial and moral supporter at the time, I resisted the urge to play detective. If I asked the mother what had happened to her second husband, she would want to know why. If she thought her daughter had killed him, that could destroy my patient's support system. On the other hand, she might have met him for lunch the previous week, for all I knew. If that were true, what was I to tell the patient? Satisfaction of my curiosity was not worth the risk of either outcome.

Other patients have ended up in the hands of police and courts, who looked to me, as the therapist, to explain what was going on. Then I was forced into the role of the forensic reporter, where my goal was different, but the patient/suspect was the same. What was I to do?

In an ideal world, I could have stayed out of the legal arena and insisted that the legal authorities bring in an outside expert to advise them. Once, I was the Program Chief of the local mental health service and one of only two psychiatrists in the county. My office partner was the other one, and he had enough work to do without taking on my cases. Also the legal authorities often considered me the only one knowledgeable about the patient/client/suspect, and they expected me to tell them enough to solve the legal problem without harming the patient. They had no desire to convict a mentally ill patient of mine if I could give them valid reasons not to do so.

A forensic reporter plays a completely different role with the client and is assigned to the case by a court or defense attorney. The reporter must quiz and examine the client to determine evidence of mental illness, as he would any patient, but his/her database is much larger than that used in a therapy situation. The reporter must review whatever documents are available that might enlighten him/her about the client's past behavior. Some of these documents have primary information, such as school or hospital records, but some have only secondary, and possibly unreliable, information, such as police interviews of witnesses and accomplices. Sometimes attorneys will hide important documents from him/her when they are trying to bias his/her report in a direction favorable to their clients.

The forensic reporter is beholden to the legal authorities for payment, and those officials must understand his report. The authorities ask questions that are in the involved legal statute, and the report must address those questions or the case will be referred on to other experts for further evaluations. The reporter is not in the position of providing treatment to the client, who may now be under the care of a jail physician.

When I was the only psychiatrist in a slum area mental health clinic, I treated many psychotic patients. One of my delusional patients invaded an elderly couple's home and accused them of stealing the house from his cousin. The police arrested him and took him in the county jail, where I conducted psychiatric sick call every Tuesday afternoon. I told the public defender this man was mentally ill, without giving details. He asked the court for a psychiatric examination regarding competency to stand trial. The judge appointed me to be the forensic reporter on the case. I responded that he was incompetent to stand trial. The law required a representative of the Director of Mental Health to recommend the proper place for treatment, and the director asked me to write that report, advising admission to the state hospital. When the hospital's staff recommended his return to court as competent, the judge asked me to write the report about his ability to stand trial. When the defendant pled insanity, I wrote the report on that issue also, with a recommendation that he had recovered his sanity and could return home. After release, he resumed treatment as my clinic patient.

That is not the way these matters are supposed to be handled, as the chances for a conflict of interest on my part were rampant. But in that small county, where I had a number of assignments while working for the mental health service, the officials trusted me to be ethical and professional in telling them what I wanted to about my patient. After his arrest, I switched roles every time I saw him. Fortunately he was a

arrest, I switched roles every time I saw him. Fortunately he was a chronic schizophrenic and not a dissociator. He did not appear to suffer from the changes in our relationship, as he was usually in his delusional world. That would not be true when the patient/client is someone who has a severe character disorder, especially someone who used dissociative defenses extensively. With those patients, severe transference and countertransference problems will inevitably arise.

The third role we therapists are tempted to play is detective. That is the one I see as causing the trouble leading to the rhetoric surrounding the debate over true or false memories, be they Satanic Ritual Abuse or UFO survivor stories. To some degree, I blame TV for fostering the idea that anyone can be a good detective, that none of us need training or experience to solve crimes. Certainly, none of us therapists need be aware of the rules of evidence adopted by our criminal courts!

Two of my favorite shows are "Murder She Wrote" and "Father Dowling Mysteries." Every week, I see examples of a writer, Jessica Fletcher, outwitting the local sheriff and identifying the killer each time. Where does she get the time and energy to track down the clues needed to find so many criminals in her small town, when she should be doing research and writing every day? Why doesn't the sheriff ever find the criminal with his own staff?

In "Father Dowling Mysteries," I see a priest and nun, Sister Stephanie, totally neglecting the daily duties of the parish and traipsing all over town chasing down crooks before the police even know someone has committed a crime. Where do they find time to do all that investigative leg work, while they are locked in freezers and dressed up as bug exterminators, when the parish has a long list of activities they should attend to? What bishop would put up with such negligence for long?

Shows like these, plus many others, give the impression that detective work is suitable for the amateur, and it is not! I have had numerous patients tell me stories of incidents that I wish I could check out. For example, one dissociating patient went into a spontaneous trance and told me that her first born daughter, who had been taken from her by her grandmother and adopted out at birth, had just died in a car crash at a designated rural intersection in Fresno county. For the first time, I had a story I could check out, but I had no idea how to persuade the Highway Patrol let me see records of accidents in Fresno county on the day reported. Three days later, I learned from her Inner Self Helper that the imagery had been concocted by her inner therapists to give her a chance to grieve over the loss of that child. There was no accident! Fortunately, I had not contacted the Highway Patrol, so I avoided looking like a fool, had they had been cooperative enough to investigate my story and learn no such accident had occurred that day at that intersection.

During my first year of providing psychiatric services in prison, an inmate with multiple personality disorder told me that, before his arrest for car theft, he had shot 11 motorists on the highways of our state. As an employee of the Department of Corrections with a responsibility to report crimes inmates admitted committing. I sent a report to the prison Security Squad. They forwarded the report to a department in the Central Office that investigates such stories. They checked every county this man had lived in, according to his police records, and found no reports of shot motorists on any highways anywhere in those counties. The Security Squad officer relayed this information back to me, but I never told the patient. Later, I discovered that the alter-personality that reported these "killings" was one that was there "to get the attention of the doctor." He only came out when he felt that I was not taking the patient seriously. Then he would say and do something that no one could ignore. He performed his mission very well!

The other factor that therapists seem to be unaware of is the change in the Shaman-patient relationship that must occur when the Shaman tries to be a detective. The Shaman is privileged to be invited along on the mental journey with the patient, and, to stay invited, the Shaman must appreciate and accept the reality of the journey. This does not mean that the Shaman has to agree with or like everything the patient says or does, but he has to identify with the patient enough to be able to understand what the patient is experiencing. When one dons the uniform of the detective, one must consider all persons involved as possible suspects, and one must doubt the veracity of any suspect. A professional investigator also keeps secret what previous suspects and witnesses have told him, so that a subsequent suspect will not know what to confirm or deny to keep a fabricated story straight.

During my involvement in a malpractice case, an investigator from the California Medical Board interrogated me regarding the actions of a misbehaving psychologist. The investigator was a former police officer who tried hard not to brag about how much he had learned from other witnesses. I tried my best to get him to tell me what he already knew so I could emphasize the points needed to counter what the psychologist had said that cast me in a bad light. We played cat and mouse with each other, since I wanted to make myself look as good as possible. Only by being the subject of an investigation did I come to appreciate the relationship that develops between the interrogator and the witness or suspect.

The investigator must be suspicious of your every word, and he will not believe you unless you agree with other reliable sources. In my case, I used his personal pride to get him to tell me what the other witnesses had already told him, so I could be sure to include facts favorable to my position.

When a therapist has had an accepting relationship with a patient and then turns into a detective, the patient will perceive the therapist as "not trusting me." This change can forever cause the patient/client/suspect to refuse to divulge any more secrets to that person. Therapy will cease immediately, and any new therapist who tries to gain the confidence of the patient will face doubt and mistrust in return.

All therapists are curious people by nature, or we could not listen to so many tales of woe. But, if our goal is the improved health of the patient who came to us with pain and bewilderment, then we must stay in the role of Shaman. The patient has graciously invited us to share the journey so that we, as Shamans, can add our own experience, judgment and insight to that of the patient, so that together we can find meaning to and resolution of the patient's plight. When our patients are in legal trouble, someone else should be the forensic reporter, while we continue to support them through this part of their journey. We must let the professional detectives do the job they trained to do, to ferret out the "consensual truth" and determine who are the liars. Detectives cannot be therapists, and therapists cannot be detectives.

Book Review

Close Extraterrestrial Encounters: Positive Experiences with Mysterious Visitors

Richard J. Boylan, Ph.D., and Lee K. Boylan, MBA, editors
204 pages, trade paperback. $12.95 from Wild Flower Press, P.O. Box 230893, Tigard Oregon 97281 (plus $2.00 for S&H), or call 1-800-366-0264

Dr. Richard Boylan is a clinical, research and consulting psychologist in private practice in Sacramento, California. He has been a contributor to BAE (Vol. 3, No. 5). His new book Close Extraterrestrial Encounters (CEE), written in collaboration with Lee Boylan, a physician relations professional who has had anomalous experiences, may well become the manifesto for those who have had positive CE-IV experiences.

This is a comprehensive work: Based on his experience with the 76 cases discussed in CEE, Dr. Boylan suggests a new psychiatric diagnosis, "Close Extraterrestrial Encounter Syndrome (CEES)," complete with diagnostic criteria and treatment protocol. A summary of his research findings, chapters on "How Close ET Encounters Affect Humans," "The Different ET Races and Missions," "The Meaning and the Message of ET Contact," and nine first-person accounts round out the book.

Dr. Boylan's research relies heavily on the reliability of both hypnotic regression (only 10% of his study group had total recall of their CE-IV prior to therapy), and personal validity ("It is a characteristic of any substantive message, that the truthfulness of it can be discerned by the inner resonance of the particular message with what we already know to be true").

CEE brings together the experiences, beliefs and counselling approaches of this segment of the CE-IV community in a concise, readable and very well organized work. It is an invaluable roadmap for this part of the territory of anomalous experiences.

...

I propose a new psychological descriptor which is generally applicable to the psychological effects of an Uncomplicated CE-IV. Such psychological effects form a recognizable cluster of symptoms, which I have termed Close Extraterrestrial Encounter Syndrome (CEES). In psychological diagnostic category terms, CEES is an Adjustment Disorder Not Otherwise Specified.

CEES is a reaction to a Close Extraterrestrial Encounter (CE-IV, remembered or repressed into the unconscious, which substantially alters the patterns of daily living and/or social relationships, with four or more of the following features:

1. Repeated anxiety/ unexplained restlessness after an anomalous event, (such as one involving nocturnal lights, viewing a UFO. a sense of a foreign presence in the house, or an unexplained detour from one's ordinary driving route);
2. Phobic reaction to phenomena associated with a CE-IV, whether remembered or repressed into the unconscious. (such as an accurate sketch of an extraterrestrial face);
3. Repeated sleep disturbance or nightmares with UFO/ET/Encounter themes;
4. Osessional "Dreams" or daytime thinking about UFO'S, ET's or CE-IVs,
5. Compulsive behavior (e.g., reading) concerning the UFO topic,
6. Unexplained moodiness/ irritability after an anomalous incident, (such as described in # 1 above);
7. Body symptoms/ marks associated with a CE-IV, (such as tiny scoop marks, or laser scars which don't bleed or hurt and which heal very quickly, or inexplicable bruises noted upon wakening consistent with an extraterrestrial hand grip, or episodic ringing in one ear, or other episodic resonance vibrations felt in a particular body site, such as the upper nasal sinus cavity or the occipital lobe region);
8. Experiencing an unexplainable substantial period of "missing time" following an anomalous incident, (such as being paced at night by a "car" with a single powerful headlight, or sitting down after dinner to watch television, immediately noticing an unusual pattern on the screen, and "waking up" at 10 a.m. the next morning unable to remember having watched TV or going to bed, etc.);
9. The sudden, unexplained onset of feelings of social nonordinariness (i.e., that one is out of kilter with the world, or that the world no longer seems as it used to);
10. Cosmic awareness (thinking about the Earth as a living whole, instead of confining one's perspective to neighborhood or town or country; or thinking about the Earth as just one among many inhabited planets) which enters with unusual frequency into one's daytime thinking;
11. Suddenly feeling an affinity for CE-IV Experiencers one reads about or hears interviewed on television, or feeling a strong attraction to extraterrestrials (described during CE-IV narratives) as somehow familiar;
12. A sense of receiving telepathic messages or repeated gifted intuitions, presumably from an extraterrestrial source;
13. A sense of one's mindspace being episodically entered into and shared with an extraterrestrial being,
14. The onset of, or marked increase in, psychic/ESP ability, (such as clairvoyance, telepathy, precognition, or telekinesis);
15. An attraction for a spirituality or religious practice based on the in-dwelling of the Supreme Source in all nature, and resultant reverence for all lifeforms as related;
16. Sense of longing for the primary-contact Extraterrestrial one has dealt with during one or more Encounters;
17. An obsessive sense of having a mission (clear, vague or unconscious) derived from the CE-IV, and related to the ETs' messages;
18. A sense of strong "pull" to travel to a specific area, either with an intuition of an impending Close Encounter there, or for an unknown reason, (which turns out to be a CE-IV);
19. Having a Extraterrestrial perspective to the Earth's situation. or feeling a genetic heritage which is partially derived from Extraterrestrial sources, or having a sense of having come from off-planet, or having somehow had an Extraterrestrial as one parent, and
20. Sense of one's destiny as off-planet, or feeling a "pull" to go "home" to an extraterrestrial planet one was shown by the Et's, or to "re-" join "fellow" Extraterrestrials elsewhere in the galaxy.

...

In contrast, a Complicated CE-IV refers to an apparent extraterrestrial encounter associated with extreme and persistent disabling psychological trauma. (PTSD). As noted earlier, in my research, these traumata are of three sources:

1. Childhood sexual abuse or rape, untreated, which causes the subject of both the human abuse and the Close Encounter to associate the two subconsciously, and attribute to the ET's feelings begun with the human abuse,

2. Unprofessional and/or biased hypnotic and interviewing techniques by an investigator whose presuppositions about Extraterrestrials cause him/her to overfocus on the frightening aspects of the Encounter; or ask leading questions (especially under hypnosis) which reframe the experience to fit the investigator's preconceived expectations about ET agenda and methods, and their supposed traumatic quality; and

3. The person has been the subject of a staged pseudo-Alien abduction conducted as a Psychological Warfare (PSYWAR) operation, involving an abduction by military/InteRigence/ special operations figures and "Aliens" (short humans dressed in "Alien" costumes); or possibly, in a few rare cases, accompanied by a few renegade Aliens. The pseudo-Alien abduction often involves

drugging, hypnosis, electroshock, the staging of terrorizing scenes in front of the abductee, exposure to disorienting electromagnetic energy fields, confusing holograms, deliberate torture, and other CIA Project-MK Ultra techniques, and is, at times, followed by cultic ritual sexual abuse by cloaked humans as well — elements not reported by subjects of true extraterrestrial encounters, that is, those involving only Extraterrestrials.

These pseudo-Alien Abductions are intended to confuse the abductee into believing that s/he has experienced a typical Encounter with Extraterrestrials. The purpose of such PSYWAR abductions appears to be to create traumatized victims, and thus to propagandize about how terrible all Extraterrestrials are, and justify a Star Wars weapons build-up to use on "those vicious Extraterrestrials". These abductions also serve to provide victims for the PSYWAR experiments of some of the darker elements of the "National Security" establishment.

...

For those persons who are not dealing with an unresolved earlier human-caused trauma, and for whom Brief Treatment is therefore appropriate, the following twelve elements of CE-IV debriefing, counseling, and clinical education are presented, for professional psychotherapists to consider including in treatment:

1. Prompt intervention is important, as close to the time of the close encounter incidents) as possible, using the Crisis Intervention and Brief Therapy models where appropriate. Or, in some cases, even a single-session debriefing/education session may be appropriate and effective with the untroubled Experiencer merely seeking validation of his/her sanity, and/or the reality of his/her close encounter.

2. As always, a rapid review of the psychological and social history of the Experiencer is in order, but with particular attention to remembered and possibly-repressed CE-IV episodes, or anomalous events which may represent close encounters repressed from memory. Simultaneously, this history-taking permits a rapid assessment of the character strengths or deficits, and psychosocial resiliency of the client-Experiencer.

3. The next step is listening with appropriate acceptance, empathy, and without unwarranted skepticism; erring if necessary on the side of acceptance of extraterrestrial encounter narratives initially. The untruthful and self-deluding will soon enough manifest their distortion of the truth, by inconsistencies, by versions of events which contradict the well-documented patterns of extraterrestrial contacts, by overly self-absorbed or grandiose tales, which have too many indications of human origin, etc. We are still learning about the varieties of CE-IV experiences, so initial acceptance seems an appropriate therapeutic stance to work from.

4. It may well be appropriate that the therapist consider the use of hypnosis, after a therapeutic alliance has been established, as indicated, (using formal trance with age regression, or ideomotor-signaling dialogue) to recover repressed CE-IV memories, and/ or to determine the reality of vague, ambiguous incidents or "Dreams". which appear to have those characteristics which suggest a possible close encounter. This will help establish the "data base" from which the clinical issues to be pursued can be extracted.

5. The next step is the working through of the reality-challenging happenings of a close encounter, with opportunity to ventilate emotions, regain a sense of one's sanity and wholeness, and develop coping skills to deal with an altered view of the world, and to deal with possible future close encounters.

6. Concurrently, the therapist should consider the integration of repressed memories of extraterrestrial contacts with remembered events, and providing appropriate exploration of what this means to the Experiencer. The therapist can also provide objective interpretation of these events in the light of known scientific knowledge about the extraterrestrials and the society-wide Denial Syndrome.

7. Another feature of a complete debriefing/counseling process is the providing of information about the extraterrestrials' behavior patterns, messages, and apparent intentions. This can be derived from other Experiencers' accounts, and from authoritative books and seminars on these topics.

8. A traditional, and never more timely, feature of psychotherapy is the providing of reassurance, support, and clarification, while the therapist models hopefulness her/himself. (for the therapist is in the CE-IV Experience by the very act of taking on the work of helping Experiencers sort out their contacts, as will become clear to the therapist soon enough). If the therapist cannot model hopefulness about the Extraterrestrial Presence phenomenon, it would be perhaps wiser to refer the client to a therapist who can bring this resource to the process.

9. Another useful feature of a complete program of counseling for Close Extraterrestrial Encounter Syndrome is providing context-restoring information about the Government's knowledge of and cover-up of the Extraterrestrials' Presence, to help the Experiencer realize that he/she is not an isolated case.

10. Because true close-encounter Experiencers tend to be natively bright people. even if not highly formally educated, it is particularly appropriate to include bibliotherapy in the program of therapy. This can be done by recommending appropriate readings and self-help books on the UFO and Close Extraterrestrial Encounter phenomena, by encouraging the utilizing of spiritual growth resources which feel authentic for the client, and suggesting to the client readings on humanitarian, ecology, global-politics, New Physics, social justice. and cosmic-perspective (i.e., Gaia hypothesis) topics. Such readings and education will serve to empower the Experiencer to take an active role in her/his own her and growth. Also, the therapist will find that many experiencers have a newfound interest or deepened intensity in these topics, as a result of extraterrestrial communications emphasizing these values during close encounters.

11. An element of the counseling process which I will boldly label 'indispensable' is connecting the Experiencer with a CE-IV support/ consciousness-sharing peer group. consisting of other actual Experiencers, and facilitated by an knowledgeable, skilled and empathetic professional. The therapist may strongly suggest that the Experiencer avoid highly-dubious New-Age "Contactee"-wannabees, and self-absorbed 'ET-channeler' groups, which can only distort and confuse the Experiencer about what is real in their experience, versus the fanciful, histrionic and hyperbolic bovine excreta which is overpresent in those other groups. (If what I have said here is not true, may Ramtha, the Ashtar Command, and Ra strike me! Not to mention, Michael.)

12. The different, and more intense and complicated Dual-Diagnosis Experiencers, (whose moderate Close Extraterrestrial Encounter Syndrome symptoms are exacerbated by flashback-linkage to previous human-caused, Posttraumatic Stress Disorder-level, untreated trauma), require specialized, and usually much lengthier, psychological treatment. As has been mentioned above, important elements of therapy include the uncovering and interpreting of the dual traumata, and their interactional effects, and treating both, (interactively and simultaneously).

Special attention must be given to counseling victims of Psywarfare-staged pseudo-ET abductions. Besides the complex issues of real human trauma of abuse, threats, torture and rape, and the confusing element of staged pseudo-Aliens involved, along with renegade military officers, these triple-victims are at significant risk of further kidnappings. threats to life and to family, and ruination of career. They must be assisted to locate trustworthy legal and logistical help, to try to minimize the possibility of further kidnappings and other risks. and helped to find supportive resources, so they can fight back, and regain control over their lives. Then there is the issue that their naive trust in a benevolent Government has been shattered, perhaps irretrievably. The therapeutic challenge is to find hope in a harsh world.

13. With delusional-disorder pseudo-Experiencers, the therapeutic task is to indicate that with the information and context that they have provided to you thus far (which leads you to conclude carefully that there is a delusion present) you do not have a basis to validate their reported experiences. And thus, it would be inappropriate to explore further that material; and more productive therapeutic effort should be directed elsewhere.

From the UFO Literature



excerpted from an interview by Sean Casteel in UFO Magazine Vol. 8 No. 5, 1993
UFO Magazine is available on many newsstands and shops, or by subscription ($21 per year, $28 foreign; Calif. residents add 8.25% sales tax). Write them at PO Box 1053, Sunland CA 91041 USA

...
UFO: Don't you think ufologists are providing at least some decent research and support regarding the abduction phenomenon?

Strieber: There are very few people even peripherally associated with the UFO community and with the so-called investigators, most of whom are rank amateurs at what they do and show it, who ever said or did anything reasonably sensible about the abduction experience or did anything positive to help the people who've had these experiences. Certainly (this applies to) these people running around hypnotizing people into believing they've been involved in this highly structured sort of "alien scientists" deal, where they've been taken in the little ship and put on a table and diddled with by what I would think by now must be incredibly stupid aliens who've been allegedly doing this same abduction thing for 25 years.

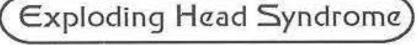
People who hypnotize people into believing that experience cause 99 percent of what actually happens to just be hidden behind a screen of false memories. And the person never even begins to get a hold of it. This thing that's happening to us — I don't even buy into the idea this is necessarily abduction by aliens, by the way -- is hard and it's awful. It needs to be worked through very carefully by skilled, open-minded professionals. By that, I mean psychiatrists and psychologists, (who can) help a person cope with this.
The frank truth is, there isn't anybody to do that. There are no professionals who know what they're doing. God knows, I've talked to dozens and dozens of them. And the psychologists and the psychiatrists, with few exceptions, are not even really trying.

The UFO investigators are way off. I mean, hypnotizing people into believing they've been abducted by alien scientists who are interested in stealing genetic material is stupid. There's no evidence of that. There's only anecdotal evidence, and the anecdotes come from a self-verifying circle of so-called (hypnotically-retrieved) memories which probably aren't memories at all. Without any direct evidence of that kind of thing, it's a fantasy to believe it has anything to do with reality at all. The whole thing is a fantasy.
...

UFO: At this point in your life, do you think the abduction experiences you went through conceivably could work out to be a positive experience? I remember that was your initial determination.

Strieber: Well, I had to, because if I hadn't thought that in the beginning, I certainly would have blown my brains out. There's no question about that at all. And if I had not made myself find something about my experience that could be made into a positive thing, I couldn't have lived. It would have meant I was living in hell, and there was no escape from it. First of all, there's nothing to be done to stop this experience. The social structures that surround it, by which I mean the UFO community, insure that the people in it will never get the advantage of having legitimate science look into it and see what's really happening. Meaning that it is, in effect, incurable. And totally misunderstood. Having had this experience and declared yourself as having had it means that you will spend the rest of your life being discriminated against just like a black in the South in 1925. I am just as discriminated against. My civil rights and my personal rights are as consistently abused as if I didn't have them. I'm treated like a madman was treated in the 18th century.
..
I've come away from this experience convinced of one thing: if there aren't demons out there, there might as well be. Because these guys are indistinguishable from demons. Indistinguishable. To see them, to look into their eyes, is to be less. Forever. It hurts you, it takes from you, forever. Because then you know that it exists. And that makes you less. And then you have to try somehow to build on the scar tissue. Just like the lady who's raped and laughed at. Build on the scar tissue. That's all you can do.

From the Medical Literature



A number of experiencers in my practice have reported hearing loud noises for which the source is unidentifiable. They are sure they heard something, and, since there is no obvious explanation, they naturally ascribe it to ETs. I didn't have a credible alternate explanation to offer them — at least, until I read the article in the Medical Post (the second item below) which not only named the phenomenon ("Exploding Head Syndrome") but reported a study which demonstrated electrophysiologic correlates of the experience. The etiology is not yet established, but it is believed to be a benign condition, and internally generated (i.e. there's nothing paranormal about it). The articles below demonstrate that physiology, and in particular neurophysiology, plays a very important role in our perceptions.

Clinical features of the exploding head syndrome
J.M.S. Pearce
Journal of Neurology, Neurosurgery and Psychiatry 1989; 52:907-910

Summary
Fifty patients suffering from the "exploding head syndrome" are described. This hitherto unreported syndrome is characterized by a sense of an explosive noise in the head usually in the twilight stage of sleep. The associated symptoms are varied, but the benign nature of the condition is emphasized and neither extensive investigation nor treatment are indicated.

...The syndrome in essence consists of an hitherto unreported benign symptom characterized by a sense of explosion in the head, confined to the hours of sleep which is harmless but very frightening for the sufferer. It receives no mention in current texts. Correspondents includes several physicians and neurologists who suffered from it, but in each case had not encountered the symptom in their own patients — "because I hadn't bothered to enquire", they typically remarked.

Clinical features
As originally stated the syndrome is exclusively nocturnal, and it is now clear occurs predominantly in the twilight stage as the patient is dropping off to sleep, or, less often, if they waken during the night and again fall asleep. Some patients simply report it waking them from sleep but without sleep monitoring it is not possible to know whether

this occurs during stages 1 to 4 or if they have woken briefly and are falling asleep again — in another twilight stage. All sufferers report noise, not pain. The dramatic nature is evident in their words "enormous roar, so loud it could kill me"; some, however, say that it can be mild and infrequent. The terror induced is notable in every case, until some degree of acceptance is achieved after many years in which they have maintained good health. Preceding events are generally unremarkable, but three physicians noted attacks to start and to recur when they were under personal stress or tired and overworked. No consistent observations were proffered in respect of "incidental medication".

[The sound is variously described by the patients in the series as loud bang, explosion, shotgun, thunderclap, loud metallic noise, clash of cymbals, electric shocks; Associated symptoms vary, and include suddenly waking, overactive mind, aura of floating, panic, sense of falling, flash of light]

The onset is ...variable; some start in childhood, but no decade is spared. The commonest age of onset remains however in middle and old age: 22 of 39 reported their first attack after the age of 51.

The pattern of episodes of explosions is also variable. Some report 2 to 4 attacks followed by prolonged or total remission, others have more frequent attacks up to 7 in one night, for several nights each week and may then remit for several months, for reasons largely unknown.

...

As a symptom it is probably fairly common. No less than fifty patients voluntarily wrote about their symptoms within 4 weeks of publication *[of Pearce's first article, in Lancet]*. But, as a source of complaint it is rare; many said they had been ashamed to mention it to their doctors or that their complaint had been greeted with incredulity if not frank disbelief. The patients are predominantly middle-aged or elderly, slightly more commonly women than men. There is little evidence of relevant past illness and no other CNS disease in evidence. The complaint is exclusively in sleep, but this may include daytime naps. The victim is aroused from sleep by a violent sensation of explosion in the head. It occurs abruptly with apparently great force, yet it is not a pain. Patients are so alarmed that at first they may, inaccurately, describe it as a pain, but closer questioning shows the awareness is not of a hurt but more of a noise deep in the centre or back of the head. By the time the sufferer is wide awake it has gone, but not surprisingly it leaves in its wake a sense of great consternation and sometimes momentary difficulty in breathing, tachycardia and sweating.

It may occur for a few weeks or months, then spontaneously disappear, or, may recur irregularly every few days, weeks or months for much of a lifetime, yet with no preceding cause in the habits or events of days prior to the attack. The patient's fear is usually of a cerebral hemorrhage, stroke or brain tumour.

It is entirely benign, and I suspect quite common, but underreported. What causes the bomb-like noise remains a mystery and I know of no vascular or hydrodynamic changes in the brain, labyrinths or CSF pathways which cause comparable symptoms. A momentary (almost ictal) disinhibition of the cochlea or its central connections in the temporal lobes might produce such a phenomenon; less likely is a sudden involuntary movement of the tympanum or the tensor tympani. Gordon has suggested rupture of the labyrinthine membrane or a springing open of the Eustachian tubes with a crack like a pistol, especially if there is a tendency to undue patency. I doubt that these tentative explanations account for the repetitive phenomenon recorded here in patients without evidence of tinnitus, vertigo or deafness.

The likeliest explanation is to class it with the other physiological phenomena such as nocturnal myoclonus, which mark the transition from wakefulness to grade 1 sleep. ...We need further studies using polysomnography employing continuous recordings of EEG, EOG, mentalis EMG, surface EMG on the limbs, ECG, nasal and oral airflow measurements as well as ear oximetry. Until more is understood of its etiology, it remains as a genuine source of distress which does not seem related to neurosis. Firm reassurance is essential but drug therapy appears unwarranted.

'Richter scale-like' readings reveal reality of exploding head syndrome
by Rick McGuire
Medical Post, August 17, 1993

...A New York University team has startling evidence that the [exploding head] syndrome is an actual electrophysiologic event. The data were presented at the Associated Professional Sleep Societies (APSS) meeting, which-includes the Sleep Research Society and the American Sleep Disorders Association.

A 47-year-old white perimenopausal female was undergoing polysomnographic and topographic electroencephalogram (EEG) mapping of sleep. She was part of a study control group and was being analyzed as a laboratory "normal." The woman's second night of sleep monitoring was, as expected, quite uneventful and she "demonstrated excellent sleep architecture." Edward O'Malley, assistant research scientist at the NYU/Bellevue Hospital sleep center, was on duty that night. He picks up the story.

"When you sit in the sleep lab at night, it's very quiet and you hear the (EEG) recorder pens barely making a sound as they print out the strip," he said. "Suddenly, there's this loud sound as if (the machine) is about to explode." The mapping returned to normal, but 10 seconds later it happened again. This time, the patient woke up and called across the laboratory, "Did you guys get that? It felt like an electrical shock went right through my whole head."

She felt the first one, too, but was trying to ignore it and continue sleeping when the second "explosion" hit and blew her awake.

When discussing the event the next morning, she said similar events had interrupted her sleep, with varying frequency, over the past 20 years. She stated that the events caused extreme anxiety and she generally struggled to wake up. She feared being "overtaken" by the event and dying. She revealed that her 24 year-old daughter suffers similar attacks during subjective dream sleep. However, the daughter had learned to control them like a lucid dreamer.

The EEG mapping done at NYU shows a dramatic event that occurs across all channels in the brain. Instead of an EEG, the strip looks more like it's measuring a 7.0 earthquake on the Richter scale.

According to Dr. Joyce Waisleben (PhD), director of the sleep center, "We were quite shocked and, yes, this is a first. It's the first time this has actually been documented."

...

Dr. Walsleben wants physicians to be aware that the exploding head syndrome exists and appears to be a true hypnagogic phenomenon and not just an expression of emotional stress in the awake state.

She said, "Once we started asking about this, we now have four patients who report it and today I've had three people come up to me and say, 'I've got it also. We've even had two doctors come up and tell us that they had patients reporting this, but they looked in the literature and couldn't find anything, so they just dismissed it and told their patients not to worry."

In fact, that may be good advice, but Dr. Walsleben emphasized that patients need reassurance, too, about the apparent benign nature of these events. "First, it really exists, so your patient isn't crazy telling you these things," she said. "'You can calm patients down by telling them, so far, no one has been able to link anything pathologic to this syndrome, so it probably doesn't produce a stroke or any of those nasty things people worry about.

"Tell your patients that some people have apparently experienced these things for years and not to worry," said Dr. Walsleben. "Being able to calm the patient, they'll think you're wonderful."

Other reports in the literature

Exploding head syndrome.
Pearce JM
Lancet 1988 Jul 30;2(8605):270-1

The Exploding Head Syndrome: Polysomnographic Recordings and Therapeutic Suggestions,
Charlotte Sachs and Eva Svanborg
Sleep 1991 14(3): 263-266

Summary

Attention has recently been drawn to a condition termed the exploding head syndrome, which is characterized by unpleasant, even terrifying sensations of flashing lights and/or sounds during reported sleep. Nine patients complaining of sensations of explosions in the head during sleep or drowsiness were investigated with polysomnographic recordings. None of them had any neurological disorder. Five patients reported explosions during the recording sessions. According to the recordings, the attacks always took place when the patients were awake and relaxed. In two cases abrupt electroencephalographic (EEG) and electromyographic changes indicating increasing alertness were recorded at the time of the reported attacks. In the remaining three cases no EEG changes were seen. Thus, there were no indications of an epileptic etiology to the condition. In all patients the symptoms ameliorated spontaneously with time. The severity of the symptoms was reduced by reassurance of the harmlessness of the condition. Clomipramine was prescribed to three patients who all reported immediate relief of symptoms. It is concluded that symptoms of this type are probably not true hypnagogic phenomena but may be an expression of emotional stress in the awake state.

[The exploding head syndrome]
Het syndroom van het exploderend hoofd.
Bongers KM ter Bruggen JP Franke CL
Ned Tijdschr Geneeskd 1991 Apr 6;135(14):617-8 (Published in Dutch)

The case is reported of a 47-year old female suffering from the exploding head syndrome. This syndrome consists of a sudden awakening due to a loud noise shortly after falling asleep, sometimes accompanied by a flash of light. The patient is anxious and experiences palpitations and excessive sweating. Most patients are more than fifty years of age. Further investigations do not reveal any abnormality. The pathogenesis is unknown, and no therapy other than reassurance is necessary.

Episodic Psychic Symptoms in the General Population

Ardila A, Nino CR, Pulido E, Rivera DB, Vanegas CJ
Epilepsia 1993 34(1): 113-140

Compare this study with the Roper Poll.

Summary

The frequency of some episodic psychic symptoms (dysmnesic, perceptual, and experiential) was determined in a 2,500-subject general population sample. Correlations with some risk factors eventually associated with nervous system dysfunctions (seizure history, head injury, car accident, hospitalization, febrile illness, and birth injury) were calculated. Subjects with one or several risk factors were more likely to report episodic psychic phenomena in daily life. Significant correlations of episodic psychic phenomena with sleep disorders, headache, allergies, and a history of learning disabilities were observed. We propose that some subclinical dysfunctions can be associated with the appearance of episodic psychic phenomena in otherwise normal subjects.

...

Psychic partial seizures (usually considered "temporal lobe seizures") include: (a) dysmnesic seizures (deja-vu, jamais-vu, memory gaps), (b) perceptual seizures (illusions and hallucinations, mainly visual, auditory, and olfactory), (c) cognitive seizures (depersonalization, derealization, forced thought), (d) affective seizures (fear, anxiety), and (e) dysphasic seizures (forgetfulness of words, paraphasias, difficulties in understanding language). The purposes of our research were (a) to establish the frequency of episodic psychic symptoms in the general population, and (b) to correlate these episodic psychic symptoms with a series of variables potentially indicative of minor CNS dysfunctions.

Method

A sample of 2,500 nonpaid volunteer students (1,244 men and 1,256 women) from different universities in Bogota, Colombia was selected. Average age was 24.07 years (SD 5.49, range 17-50).
An adapted version of the questionnaire of Roberts et al. (1990), including 72 questions, was used. This questionnaire was designed to establish (a) the frequency of some perceptual, experiential, and dysmnesic partial symptoms in the general population; (b) the frequency of some CNS risk factors and their correlations with the psychic partial symptoms; and (c) the frequency of some associated dysfunctions and their correlations with the psychic partial symptoms.

Results

...About 50% of the cases had scores of 0 ("never"), indicating that in the studied population, the frequency of psychic partial symptoms was low. The events most frequently reported were dysphoric spells, episodic euphoria, religiousness, sweating, excessive shyness, and deja-vu. The most unusual phenomena were unrecalled behaviors, sexual failure, somatosensory illusions, and suicidal ideation. A significant dispersion in scores was observed. Although average scores were 0-1, a varying percentage of subjects had scores of 2, 3, and even 4.

Correlations between predicting variables (risk factors) and symptomatic variables (episodic psychic symptoms) were calculated. A $p < 0.0001$ level of significance was selected. Seizure history was significantly correlated with seven symptomatic variables (episodic vertigo, visual fixation, confusional spells, environmental distortion, paranoia, episodic anxiety, and suicidal ideation). Head trauma history was correlated with five symptomatic variables (visual illusions, auditory illusions, episodic vertigo, visual fixation, and confusional spells). Car accidents were correlated with unrecalled behaviors, visual hallucinations, syllabic iterations, and tachycardia. Febrile illness was correlated with 19 of the symptomatic variables. Hospitalization with unrecalled periods correlated with three symptomatic variables (paranoia, dysphoric spells, and episodic anxiety), and a positive history of birth hypoxia (to the subjects' knowledge) correlated significantly with six symptomatic variables (episodic vertigo, visual fixation, confusional spells, environmental distortion, episodic anxiety, and tachycardia).

...

Sleep pathologies, especially irresistible sleepiness, correlated with all symptomatic variables analyzed, thus appearing as the strongest variable. Somnambulism history correlated with 22 of the symptomatic variables. The sleeping disorders considered thus showed a highly significant correlation with the appearance of episodic psychic symptoms. For all the abovementioned correlations, a significance level of $p < 0.0001$ was observed.

Discussion

...

The frequency of the episodic psychic symptoms in our sample was in general higher than that reported by Roberts et al. (1990). The observed frequency of the 4-score answer (at least several times a week) in our sample was approximately twice that reported by Roberts et al. (1990). However, the prevalence of epilepsy in Colombia is significantly higher than the prevalence usually reported, as is apparently equally valid for other Third World countries . This might be interpreted as an increase in some risk factors not only associated with a higher prevalence of epilepsy, but also with a higher frequency of some minor CNS dysfunctions.

...

Individuals with a history of suicide attempt had a very high frequency of psychic partial symptoms. Suicide ideation was significantly correlated with suicide attempt history ($r = 0.43$; $p < 0.0001$). Subjects with suicide ideations and suicide attempts had a significantly

increased frequency of drug abuse and sleeping disorders.

...

The presence of episodic psychic symptoms probably is significantly associated with two different types of variables: (a) individuals who have an increased frequency of episodic psychic phenomena also have a higher frequency of some risk factors of CNS disease or dysfunction (convulsion history, head trauma, car accident, hospitalization, febrile illness, and birth injury), and (b) an important association exists between the frequency of episodic psychic symptoms and sleep disorders, headache (likely migraine type), learning disability history, and allergy.

Table 1. Percentage of response in each category

(The following are selected elements from the Table that are of particular relevance to the abduction phenomenon - Ed.)

Code: 0 = never; 1 = less than once a month; 2 = at least once a month; 3 = at least once a week; 4 = at least several times a week

Variables	0	1	2	3	4
Unrecalled behaviors	72.52	17.72	7.36	1.88	0.52
Memory gaps	45.96	28.68	17.80	5.56	2.00
Visual illusions	34.36	26.88	24.16	10.64	3.96
Illusion of movement	40.20	33.68	19.28	5.44	1.40
Auditory illusions	42.12	32.64	18.24	5.60	1.40
Episodic tinnitus	25.40	34.72	25.56	11.28	3.04
Haptic illusions	46.44	29.24	16.88	5.80	1.64
Somatosensory illusions	72.48	17.00	7.56	2.12	0.84
Olfactory illusions	41.84	29.92	17.16	8.24	2.84
Gustatory illusions	49.68	30.12	14.08	5.00	1.12
Visual hallucinations	63.36	20.88	11.08	3.52	1.16
Environmental distortion	46.80	31.84	14.92	4.88	1.56
Impending doom	48.24	26.24	14.84	7.52	3.16
Paranoia	46.88	30.20	15.16	5.76	2.00
Religiousness	23.48	28.36	24.96	16.40	6.80
Episodic anxiety	34.56	32.04	20.76	9.32	3.32

The Polygraph

Recently a correspondent asked whether there might be a use for the polygraph (lie detector) in abduction investigation (including identifying abduction experiences whose cause might be a dissociative disorder). I found this an intriguing question. It reminded me of "Lie Detector," the syndicated television series of five or so years ago hosted by attorney F. Lee Bailey. People who felt they were unjustly accused or convicted of a crime would tell Bailey their story, then submit to a polygraph test. In the climax of the show the test would be interpreted by the polygrapher, who would tell the subject whether he was telling the truth or not. Occasionally a guest who professed innocence but who failed the polygraph test would stomp off the set angrily cursing Bailey and the polygrapher, sometimes breaking a prop or hurling a chair on his or her way out.

Towards the end of the show's year-long run, having exhausted the available supply of interesting criminal cases (and with Judge Wapner taking care of civil cases), the show looked elsewhere for material, and invited Betty Hill to appear on the program. She passed the lie detector test. Bailey added a caveat at the end of the show that this simply proved Betty Hill believed that what she was saying was the truth.

Anyway, a literature search on MEDLINE and PsychINFO turned up very little on polygraph use in dissociative disorders (and absolutely nothing on polygraphs in multiple personality disorders). Most of the clinical literature on polygraphs focuses, as one would expect, on its validity in determining guilt. Excerpts from two of the relevant articles I found appear below.

Regressive Hypnosis and the Polygraph: A Case Study

Charles B. Mutter, M.D.

American Journal Of Clinical Hypnosis, Volume 22, Number 1, July 1979

Abstract

This presentation deals with the examination of a female witness and possible suspect involved in a double murder. A polygraph apparatus was attached to the subject during the hypnotic regression. An ideomotor response signal equivalent to a polygraph type response was also utilized. The findings were significant psychodynamically and may explain why reliability of such procedures is deemed questionable.

...In June, 1977, the author was asked to examine Kay, a female witness and possible suspect to a double murder in Miami. Kay's boyfriend was a drug courier who had "ripped off " a drug dealer. The boyfriend planned to kill the dealer because he feared retaliation. Kay went with him to the drug dealer's house, both armed with guns. The victim opened the door. Kay's boyfriend told her to go upstairs to see if anyone else was present in the house and he killed the victim while she was upstairs. She found a girl there and, despite Kay's protests, the boyfriend killed the girl. Both left the house shortly thereafter and Kay's boyfriend left town.

Kay feared her boyfriend would return to kill her because she had witnessed the shootings. She also felt guilty and went to the State Attorney's office to give evidence. The State Attorney said he would grant her immunity if a polygraph test indicated that she had not killed either person. She submitted to polygraph testing and failed. She told the State Attorney she was innocent, despite the test results, and was willing to do anything to prove her innocence. Kay went to a hypnotherapist in a neighboring town, hoping that he could help her feel less anxious and that she would then be able to pass a second test. She stated that she was placed in hypnosis but was not helped: she failed the second test. Kay told the State Attorney she was still willing to do anything to prove the veracity of her claim. The State Attorney subsequently called the author for consultation.

...[The author's] tentative diagnosis was agitated depression with passive dependent features.

The author saw Kay [for hypnosis] on July 1, 1977. She was placed in trance state in the presence of her attorney and a Polygraph operator. A polygraph apparatus was attached and operated throughout the entire session. Analgesia was demonstrated. She appeared to be in a medium depth trance state. Her left hand was dissociated, and an ideomotor response signal equivalent to a polygraph type response was used throughout the session. The examiner suggested that whenever he tapped the dorsum of Kay's left hand, the index finger

and thumb would touch briskly, like a reflex. This was repeatedly tested and operant throughout the session. Kay was regressed to the time of the offense. The ideomotor response was again reinforced with the added suggestion, "Your index finger and thumb will touch whenever I tap your hand or whenever you say anything that is not true."

Kay's verbalizations in hypnosis were essentially consistent with information elicited in a total waking state. She did not show signs of age regression, but she did have recall and revivification. It was noted that marked anxiety was demonstrated when she described guns and the discovery of the female victim. She was asked if she killed the girl. When she said "No," the GSR (galvanic skin response) changed, indicating deception; but there was no ideomotor response. The conflicting responses suggested that Kay's unconscious mind believed she killed the girl. Further questioning revealed that Kay felt guilty when she found the female victim and felt directly responsible for her death, even though she pleaded for the victim's life. The author then asked Kay if she pulled the trigger. When she said "No, " the GSR changed, indicating no deception; and the ideomotor response was consistent. A dissociation technique was then utilized by having her watch a replay on a television screen to detach her emotionally from the crime. Her responses were consistent with those previously described.

Based on the above, the author rendered an opinion that Kay was telling a credible story; and the responses on the polygraph were due to anxiety and guilt, rather than conscious suppression of information. Kay was given immunity, and her boyfriend was apprehended.

...

In summary, a case study is presented in which regressive hypnosis and polygraph are used concurrently to determine the veracity of statements pertaining to a criminal offense. It is difficult to produce scientific conclusions from a single case study; however, this study is unique since it deals with an authentic rather than a simulated occurrence. *One may easily conclude that this study strongly demonstrates how the unconscious mind can modify psycho-physiological responses if guilt is present, and alter them once the pathologic dynamics are found and worked through [BAE's italics].* In this case the subject had an unconscious need to be seen as guilty even though she had not pulled the trigger. The concrete thinking in hypnosis (and in the unconscious mind) was involved in the idea that she had killed the girl. The ideomotor response did not indicate deception. One may suggest that the ideomotor response is more accurate than the polygraph, but an advocate may suggest it was not always operant. Perhaps one way to test the ideomotor response would be to induce posthypnotic amnesia and bring the patient out of trance without removing the ideomotor suggestions to see if the ideomotor responses were actually operant.

Conclusion

Observations from this case report are:

(1) Polygraph testing is sensitive to the wording and type of questions asked.

(2) Dissociative ideomotor responses may be useful as a polygraph device.

(3) Depth of trance is important when ideomotor deceptive devices are employed.

(4) Underlying psychodynamics are very important and must be carefully evaluated prior to and during regression [BAE's italics].

It is well established that people can lie, fantasize or confabulate responses while in hypnosis. Further studies are suggested to establish veracity of polygraph type techniques in medicolegal proceedings.

New Directions in Applied Psychophysiology

J. Peter Rosenfeld

Biofeedback and Self-Regulation, Vol. 17, No. 2, 1992

It has always been the case that there are two main branches of applied psychophysiology: (1) diagnostics and (2) therapeutics. Many of the older directions of applied diagnostic psychophysiology served mostly a heuristic value. The best known (if most controversial) diagnostic applications were in the physiological detection of deception: "lie detection." The diagnostic categories were dichotomous: guilty or innocent. Proponents of this approach argued that the act of lying led to emotional concomitants expressed by the peripheral actions of autonomic nervous system (ANS). Thus two kinds of deception tests were devised using polygraphic ANS indexes of emotion, the "guilty knowledge" test and the "control question test". The former is established as an accurate diagnostic test in laboratory and field situations; however, it has two critical limitations. (1) It cannot be used when details of the crime have been published (e.g., in the news) or if for any other reasons an innocent person has acquired the critical guilty knowledge upon whose recognition and concomitant ANS reactions this guilty-knowledge test depends. (2) As its leading proponent has noted, the guilty knowledge test also requires that much investigation and care must be invested *to develop a unique test in each case* and the resulting required amount of time and resources are typically more than most agencies have available. Thus the "control question" polygraph test has been offered as an alternative that does not depend on developing a critical guilty knowledge data base (e.g., a set of crime scene details), but which puts simple, direct questions to subjects, e.g., "Do you use cocaine?" Some clever researchers have developed objective, computerized versions of this test, and have provided supportive data in laboratory ("mock crime") models of criminal investigations, however, there have been few controlled studies of the method in the criminal field and only one in the preemployment situation. (This is partly why most preemployment polygraph tests were banned in the U.S. in 1985.) The diagnostic success rate, and thus the method itself, have been highly controversial and critics have suggested that a 50% (chance) hit rate is typical of the results with *innocent* persons. Thus what I call "lower body" (ANS) lie detection methods which have involved some of the most creative minds in psychophysiology have not really given us a solid application, though they have given us a powerfully influential heuristic push.

What the bottom line of the ANS polygraphic lie detection story reveals (for me) is the essence of the difference between the older and the newer directions in applied psychophysiology: Lying may involve emotional reactions in some individuals - it doesn't in others, e.g., in psychopaths, who ironically comprise the most prominent criminal subpopulation - but even when there are emotions, they probably vary across individuals, which follows from the Laceys' (1958) principle of response specificity. A *specific* pattern of ANS signs of "guilty" emotions across all persons is probably nonexistent. This is surely related to the general nonacceptance of ANS polygraph methods by psychophysiologists.

If we think about what lying is, it is not surprising that *lower body* (ANS-based) methods have not provided a satisfying answer to the deception-detection question. Lying is saying something that one *knows* to be untrue. The word "knows" was emphasized, because lying is more directly a matter of *cognition* (knowing) than of emotion; i.e. it is more *specifically* related to knowing than to emoting. In the 1940s and 1950s when ANS polygraphy was first developed, ANS indices were the best physiological indicators of emotion (or cognition) we had, so it was reasonable at that time to explore the utility of these measurements for various applications, including lie detection.

Now however, we know of much more *specific and recently discovered* indicators of cognition — cognitive event-related brain potentials. These have been recently used with increasing success in detection of deception as well as in other applications where we need a specific physiological indicator of a cognitive event. After all, cognition must happen first in the *brain,* well before *secondary* accompanying ANS signs are generated. Cognitive event related brain potentials are direct brain recordings; it is no wonder that they would appear to have more promise for providing cognition signs than do lower body signs.

The above arguments thus point to two major new directions in applied psychophysiology: (1) the tendency for increased utilization of *brain-index-based* measures of cognition and (2) the tendency toward utilization of increasingly *specific* indicators of various physiological conditions.

Literature Roundup

Memory

Implicit perception, implicit memory, and the recovery of unconscious material in psychotherapy.
Bornstein RF
J Nerv Ment Dis 1993 Jun;181(6):337-44

A review of the empirical literature on implicit perception and implicit memory reveals that Freud's hypotheses regarding free association, transference, and the recovery of unconscious material in therapy were correct in some areas and incorrect in others. Empirical evidence confirms that — as Freud hypothesized — when implicit (i.e., unconscious) perceptions and memories are made explicit (i.e., conscious), individuals are able to make more logical, realistic judgments and inferences regarding those perceptions and memories. However, empirical evidence does not support Freud's contention that free association is a particularly powerful tool for accessing unconscious material. The implications of these findings for psychoanalytic theory and therapy are discussed, and alternative approaches to accessing unconscious material in psychotherapy are described.
...

(from the article:)...For example, recent research by Jacoby and his colleagues has demonstrated that subjects make logical, "realistic" inferences regarding explicit memories for prior events, but make relatively inaccurate, illogical inferences regarding implicit memories for similar prior events. The results of one recent study provide a striking example of this phenomenon. In this experiment, subjects read a list of nonfamous names (e.g., Sebastian Weisdorf) under one of two conditions. Half the subjects read the names under conditions in which they could devote full attention to the task, and half the subjects read the same list of nonfamous names under divided-attention conditions. Subjects were later asked to indicate which of the previously read names belonged to famous people. Jacoby et al. found that subjects in the divided attention (i.e., implicit memory) condition misidentified a substantial number of the nonfamous names, erroneously asserting that these names belonged to famous people. Subjects in the full-attention (i. e., explicit memory) condition made significantly fewer errors than did subjects in the divided-attention condition.

Jacoby et al.'s study has a number of important implications for our understanding of unconscious memories, but in the present context, one aspect of these findings is particularly noteworthy: Subjects whose memory for nonfamous names was implicit (and hence inaccessible to conscious awareness) erroneously assumed that the names belonged to famous people significantly more often than did subjects whose memory for the nonfamous names was explicit (and hence accessible to conscious awareness). Apparently, subjects in the implicit memory condition misattributed familiarity (i.e., previous exposure) to fame. However, subjects in the explicit memory condition knew that they had just been exposed to these names, and therefore concluded that their familiarity with these names was not an indication that the names belonged to famous people. Thus, subjects in the explicit memory condition were better able to make accurate judgments regarding previously seen stimuli than were subjects in the implicit memory condition.

Similar results were obtained in a series of studies by Bernstein and his colleagues. Paralleling Jacoby et al.'s "famous name" results, Bomstein and D'Agostino found that when subjects were subliminally exposed to a series of visual stimuli (e.g., photographs of college students), they made significantly more errors (misattributions) regarding these stimuli than did subjects who were exposed to supraliminal presentations of the same stimuli. Moreover, recent studies suggest that these judgment errors take place unconsciously and automatically, and are difficult to control or inhibit. Apparently, subliminal (i.e., implicit) perception of stimuli has much the same effect on subjects' judgments as does implicit memory for previously seen stimuli. In both instances, subjects cannot recall the source of their contact with the stimuli, and therefore are susceptible to all sorts of errors and misattributions as they try to make inferences regarding the stimuli

Hypnosis

Day persons, night persons, and variability in hypnotic susceptibility.
Wallace B
J Pers Soc Psychol 1993 May;64(5):827-33

Day persons (those most alert during daytime hours) and night persons participated in 2 experiments to examine within-subject variability of scores over time on the Harvard Group Scale of Hypnotic Susceptibility, Form A, and the Stanford Hypnotic Susceptibility Scale, Form C. Regardless of scale used, day persons exhibited peak susceptibility at 10 a.m. and 2 p.m.; for night persons, peak susceptibility was found at 1 p.m. and between 6 p.m. and 9 p.m. Furthermore, 2 peaks of temperature increase (1 p.m. and 6 p.m.) appeared to be associated with peaks in hypnotic susceptibility. However, such was shown to be associated with periods of food intake rather than with increases in hypnotic susceptibility. Results are examined with respect to methodological concerns and the potential existence of ultradian rhythms for hypnotic resonsiveness.

Persinger's Corner

Vectorial cerebral hemisphericity as differential sources for the sensed pesence, mystical experiences and religious conversions.
Persinger MA
Percept Mot Skills 1993 Jun;76(3 Pt 1):915-30

Multiple variants of the sensed presence often precede mystical and religious experiences that are frequently followed by sudden, permanent changes in self-concept. The model of vectorial hemisphericity assumes that the relative metabolic activity of synaptic patterns between the cerebral hemispheres at the time of transient interhemispheric intercalation determines the affect, content, and type of experience. Depending upon the relative activity of the two hemispheres, intrusions of the right hemispheric equivalent of the left hemispheric (and linguistic) sense of self generate experimental phenomena that include "evil entities," gods, out-of-body experiences, and alterations in space-time. Conditions that facilitate interhemispheric intercalation and the generation of these experiences are discussed.

Dissociative Disorders

Dissociative disorders in psychiatric inpatients.
Saxe GN van der Kolk BA Berkowitz R Chinman G Hall K Lieberg G Schwartz J
Am J Psychiatry 1993 Jul;150(7):1037-42

OBJECTIVE: This study attempted to determine 1) the prevalence of dissociative disorders in psychiatric inpatients, 2) the degree of reported childhood trauma in patients with dissociative disorders, and 3) the degree to which dissociative experiences are recognized in psychiatric patients. METHOD: A total of 110 patients consecutively admitted to a state psychiatric hospital were given the Dissociative Experiences Scale. Patients who scored above 25 were matched for age and gender with a group of patients who scored below 5 on the scale. All patients in the two groups were then interviewed in a blind manner, and the Dissociative Disorders Interview Schedule, the Traumatic Antecedent Questionnaire, and the posttraumatic stress disorder (PTSD) module of the Structured Clinical Interview for DSM-III-R, Nonpatient Version, were administered. Chart reviews were also conducted on all patients. RESULTS: Fifteen percent of the psychiatric patients scored above 25 on the Dissociative Experiences Scale; 100% of these patients et DSM-III criteria for a dissociative disorder. These patients had significantly higher rates of major depression, PTSD, substance abuse, and borderline personality than did the comparison patients, and they also reported significantly higher rates of childhood trauma. Chart review data revealed that dissociative symptoms were largely unrecognized. CONCLUSIONS: A high proportion of psychiatric inpatients have significant dissociative pathology, and these symptoms are underrecognized by clinicians. The proper diagnosis of these patients has important implications for

their clinical course.

Culture-Sensitive Psychiatry

Culturally sensitizing psychiatric diagnosis. A framework for research.
Rogler LH
J Nerv Ment Dis 1993 Jul;181(7):401-8

The convergence between the demystification of psychiatric diagnosis and the increasing professional awareness of a cultural viewpoint offers the opportunity for research to systematically address issues of culturally valid diagnosis. To organize such research, a three- level hierarchical framework is developed which integrates hypotheses about the role of culture, beginning with symptom assessment, then the configuring of symptoms into disorders, and finally the interpersonal situation of the diagnostic interview. An examination of cross-cultural research and research on cultural minorities shows how errors accumulate from the first to the third level because of the neglect of culture or through misconceptions of the concept. The framework is premised upon the need to make programs of research the driving force behind long-range efforts to culturally sensitize psychiatric diagnosis.

Religious and Shamanic Healing

Epistemologies In Religious Healing
David Hufford
Journal of Medicine and Philosophy 18:175-194, 1993

Religious beliefs in miraculous healing through prayer remain prevalent in modem society. Most such beliefs do not conflict with medical advice but some do. Conventional views have considered these beliefs incompatible with rational modern thought, predicting their demise and explaining their persistence in terms of non-rational thinking, "special logics" and psychological compartmentalization. However, attention to the actual beliefs of individuals often reveals them to be rationally ordered and empirically founded. Further, they do not usually involve disbelief of medical knowledge. Their differences from each other and from orthodox medical ideas arise from differing assumptions, the crediting of subjective experience, and the particular experiences of believers.

The Experiential Foundations of Shamanic Healing
James McClenon
Journal of Medicine and Philosophy 18: 107-127, 1993

An experience-centered approach reveals empirical foundations for shamanic healing. This article is based on data derived from surveys of Chinese, Japanese, Caucasian-American, and African-American populations and participant observation of over thirty Asian shamans. Respondents reported anomalous events such as apparitions, extrasensory perceptions, contact with the dead, precognitive dreams, clairvoyance, and out-of-body experiences. Based on folk reasoning, these episodes support belief in spirits, souls, and life after death. Shamanic healers have a far greater propensity to experience anomalous events than general populations and to use their beliefs arising from these episodes to produce ceremonies that change clients' perceptions of their illnesses. Although the foundations supporting shamanism differ from those sustaining Westem medicine, both traditions provide experiences that convince clients that specific procedural methods alleviate illness.

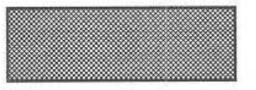
Consciousness

Modern Bioelectromagnetics & Functions of the Central Nervous System
Robert O. Becker, M.D.
Subtle Energies, 1993; 3(1): 53-72

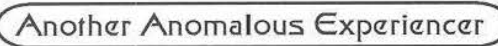
Contrary to prevailing neuron doctrine, the glial substrate and other perineural structures of the central nervous system, through their sensitivity to extremely low levels of electric currents and magnetic fields, may directly control brain functions. The neuronal brain is not only supported by, but modulated by, the glial brain. Decades of research findings which support this view are examined, and genetic and behavioral effects evaluated. Electromagnetism and its effects on the "integration of brain function" in consciousness are considered, and in conclusion it is hypothesized that DC and low-frequency extraneuronal electric currents generated in, or transmitted by, the glial components of the brain may be the basis of perceptual awareness.

Towards an Adequate Epistemology for the Scientific Exploration of Consciousness
Willis W. Harman
Journal of Scientific Exploration, 1993: 7(2): 133-143.

The scientific exploration of phenomena and experience relating to consciousness (a category which includes many "anomalous" phenomena) has long been hampered by two obstacles. One is that subjective experience does not meet the commonly accepted criteria for data in a scientific analysis, in that it is not public, objective, and replicable. The other is that many consciousness-related phenomena do not appear to fit comfortably into the accepted scientific worldview. Scientists have improvised ways of dealing with these two obstacles, so that for much of practical science (e.g. research on pain) they don't get in the way. Nevertheless, the situation can hardly be considered satisfactory. Two concepts have recently come to light which may help liberate us from this predicament — one new, the other revived from the respected writings of American philosopher William James. The first, based on recent work by Max Velmans, invovles a different model of perception; the second, referring back to James' concept of "radical empiricism," proposes a different criterion for admission of scientific data.



Experiencers' Section



by Lindy Tucker
c/o P.U.R.E. Research, P.O. Box 627, Sebring FL 33871

Anomalous experiences. I've sure had them. They range from repeated UFO encounters that coincided with audible sounds and electro-magnetic effects to telepathic and psi-related phenomena that have helped to change and direct my life. As I consider myself a fairly private person, and one who was ridiculed for many years by divulging my experiences, I feel it is timely to be sharing them with you. I've had help in piecing this all together, so I don't feel as "alienated" as before. However, I realize my life is far from "normal" as well!

My UFO encounters started in the Spring of 1975. I was twenty-five at the time and my husband and I were living in a rural farming community in Southern Ontario. He had given me a journal that year over Christmas, so I have everything recorded. This has proven a bonus for my research. It was late in the evening of March 3rd, 1975 and I was upstairs reading a book when I was taken with a peculiar feeling that I needed to get dressed and go look out the back of our house, that I would **see something.** Upon following this instinctive "feeling", I immediately saw three brilliant white lights hanging low in the Eastern horizon. I called to my husband and our neighbour who were upstairs watching T.V. to come and see these things. We watched them for approximately 20 minutes before they all **banded together into one** and blinked out! We just shook our heads and went back indoors. A couple of weeks later I was standing at the kitchen sink washing dishes around 7:30 p.m. when this same peculiar feeling came over me. This time I just stepped outside and was surprised to see five brilliant objects awaiting my attention. This was the beginning of many such telepathic episodes concerning this aerial phenomena. The "lights" would appear in different numbers and do impossible aerobatic maneuvers in the sky. They would band together and blink out, only to re-appear and split apart again! Their movements were angular or triangular; and they would change from white to yellow to

red and to green. They became so commonplace, I would often invite my friends or neighbours over at a specific time to watch the aerial displays. We were very rarely disappointed. A few weeks later on April 26, 1975, I heard a very loud, metallic beeping sound coming from the area of the bush where the sightings were taking place. My heart leaped! It sounded mechanical, similar to submarine sonar. It also had a rotational quality to it. My friends became concerned about me: "Lindy's not only seeing lights, but now she's hearing beeping sounds!" Lucky for me it wasn't too long after this I'd prove them wrong.

The evening of May 19th, 1975 was a warm spring night. We had been sitting out by a bonfire with our neighbours in front of our large garden. We noticed the animals were restless; you could hear the cows bawling for miles. Dogs were barking, and the chickens were clucking and the roosters were crowing. For all this excitement you could feel in the air at 10:30 p.m., I remember remarking to my neighbours it sounded like the beginning of an old T.V. program with Clint Eastwood called "Rawhide". We disbanded shortly thereafter and while putting the days' garbage out the back a couple of hours later, I noticed the beeping sounds coming out of the bush loud and clear and decided to call my neighbours to investigate. It wasn't long after that, that we experienced a close encounter of a spinning metallic disk, with a lighted dome on top of it! The beeping sound stopped as it rose out of the woods, did a hard, right-angle turn and came towards us in an arc. It was awesome and nobody made fun of me after that. As a matter of fact, two other farmers living in close proximity to us, came to tell me of their own experiences with a similar craft while they had been out on their tractors.

From here on in, I was basically "on my own". Everybody else preferred not to know what was there. My neighbours had been frightened by it. I had experienced a curious mixture of awe and fear. I was "hooked". I wanted to know more. The sightings continued, so did the beeping sounds. Often as I would approach the source of the sound, it would speed up or get louder. My cats would already have beat me down to the bush and would be sitting on fenceposts facing the sound, listening intently. If you whistled the same pitch as the sound, it would speed up and turn into a **vibration** that would literally shake the ground before returning to its normal frequency. If you got too close to it, it would simply stop and re-appear in another location instantaneously

I noticed upon returning to the house one night, that a simple compass spun wildly in my hand. As I glanced up at a large Elgin electric clock on the kitchen wall, the sweep second hand stopped. It was something I could repeat at will that night. All kinds of strange things started happening after that. I often would see small, gaseous orange balls of light floating in the back yard. During the daylight, there were gossamer strands of angel hair floating through the town. On a couple of occasions while driving to visit friends in other townships, these "lights" would follow our car; turning when we turned, stopping when we stopped, and returning with us when we returned home. Battery-operated devices would go dead in close proximity to the beeping sounds. One night a Professor of Astronomy from York University came over and we finally managed to record these sounds after much effort and frustration when his tape recorder refused to work. This recording has been the one piece of evidence I have been able to compare with other identical recordings I have collected over the years (that were recorded during similar UFO encounters.)

There was a strange rapping in one room in the house. It sounded like an Indian rubber ball bouncing. When trying to talk to an important investigator on the telephone, we were either disconnected by an invasive air-raid siren sound, or our voices would get so faint that static would take over and disconnect us. I started to get **crushing** headaches that would incapacitate me. It was like an ax stuck in the back of my head. I had periods of extreme drowsiness that forced me to lie down where-ever I was travelling. I found burns on the back of my neck a couple of times, when I knew I hadn't even been outdoors. It wasn't even the summer season! I found three perfect pinpricks in a perfect triangle on my left forearm one morning. I had missing time. I even remember having a couple of major anxiety attacks while indoors with a large crowd of people. This hasn't happened since, I might add.

That season, I grew a **huge** 75 lb. cabbage, which made the local newspapers. I took some Polaroid pictures and there were super-imposed images of the previous pictures on the new film, (which is technically impossible).

I was starting to get over-loaded. When I had precognitive feelings of a dear friends' accidental death and more telepathically-induced sightings, things started to become suddenly clear to me, and I became frightened. I was opening up much too fast. These series of events lead me into a desire of knowledge of nutrition, politics and cosmic cycles. Soon after, my husband and I moved out of the area and things slowed down for awhile. But they have not stopped. I rarely spoke of my experiences to anyone after this. All I found was ridicule or disinterest. (Disbelief is more like it!). Throughout the years, I can tell you it has taken rare friends to stand by me through thick and thin. I had trouble with my spouse, my family and an occasional coworker when faced with the reality of my experiences. This isolated me emotionally from many people, and those I **did meet,** I usually kept this other part of me out of the conversation for fear of losing their friendship.

As UFO research started to blossom in the mid 1980's, I sought out professionals with whom I could safely share my story. I was lucky to be introduced to a man whom I deeply respect for all the tireless research he has given this field; the eminent psychiatrist Dr. Berthold Schwarz of Vero Beach. Over the years he has introduced me to others who've had similar (or more bizarre) experiences. I don't feel so alone now. He has given me some perspective as to **what** has happened to me and **what is** happening to me. It all hasn't stopped. If anything, there are certain re-occurrences that tie into a much larger picture; one that includes the public at large and current major mysteries, such as crop circles. Something enormously exciting is afoot and I seem to have a front row seat. It is fascinating to watch it all unfold.

Through my research I have found eight other reported (and/or) recorded beeping UFO's that have occurred here in North America over the past twenty-five years. And there are more cases out there. The most recent case I found happened to a family up in New Hampshire last year. I am currently working with a titled Aerospace Professor, who has some of the world's most unique analysis tools for the sound research, and his findings are promising, although not conclusive.

I have learned to integrate all this into my personal life, although it hasn't been easy. My sensitivity to external forces are at an all-time high. I have developed empathetic, pre-cognitive, and telepathic abilities. There are spurts of psychokinesis and electrical malfunction at the most unusual times. I have learned to **read** the signs and watch carefully for what awaits us all around the corner. We live in more than a three-dimensional Universe. I feel this fourth dimension is overlapping on our day-today lives. It is growth. It is evolution. And it is coming closer to us each and every day.

In Closing

Tips for a Successful Game of Golf

by David Ritchey, Ph.D.

Late June seemed like an ideal time to get away from my hypnotherapy practice and have an opportunity to think about something other than personal growth and the working of the human mind. I attended a five-day session at the Stratton Mountain Golf School in late June and had the good fortune to have as my instructor, Kenny Lind, the "old man" among the teaching professionals. Kenny, at 75, has seen a lot of golf and a lot of golfers, and has the wisdom to emphasize the basics, stress simplicity, and focus on consistency. Here's what I learned from him:

"Par for the course" does not imply mediocrity.
Keep your eye on the ball.
Keep your chin up.
Don't hold on too tightly.
Get to the bottom of it.
Take your time when changing directions.
Consider all of your options.
Stay in the present moment.
Take it easy.
Don't block yourself.
Play it as it lies.
Get the lay of the land.
Play the "fairway"; avoid going "out of bounds."
Treat your mistakes not as failures, but as learning opportunities.
Trust your instincts, trust your experience, trust yourself.
Strive not for perfection, but for personal excellence.
Set your goals in accordance with your abilities.
You're only human.
Play for fun; it's not just about keeping score.
Remember, it's only a game.

While I didn't accomplish my original objective of getting away from the type of thinking that characterizes my professional practice, I certainly learned a lot about golf (and about living) and had a wonderful time as well.

Quotations

The trouble with radicals is that they only read radical literature, and the trouble with conservatives is that they don't read anything.
John Kenneth Galbraith, "A Life in Our Times"

Though faulty hypotheses are excusable on the grounds that they will be superseded in due course by acceptable ones, they can do grave harm to those who hold them because scientists who fall deeply in love with their hypotheses are proportionately unwilling to take no as an experimental answer. Sometimes instead of exposing a hypothesis to a cruelly critical test, they caper around it, testing only subsidiary implications, or follow up sidelines that have an indirect bearing on the hypothesis without exposing it to the risk of refutation...I cannot give any scientist of any age better advice than this: the intensity of the conviction that a hypothesis is true has no bearing on whether it is true or not.
PB Medawar, "Advice to a Young Scientist"

It is easy to be overconfident about new knowledge such as genetic engineering, and to forget that we still do not know the causes of four of the five commonest diseases: cardiovascular [disease], mental [illness], arthritis and cancer. ...
The great need for openmindedness becomes apparent. Humility, properly defined, enlarges the concept of open-mindedness. It is not to be confused with being humble. I offer you this definition of humility: "It is an open-mindedness that is acquired by an understanding of the meagre state of our knoweldge in relation to the vastness and elusiveness of the ultimate truth." The greatest threat to humility is undue veneration of knoweldge.
Wilfred E. Bigelow, OC, MD, "A Case for Caring," CMAJ 1993; 148(9), 1610-1612

Even facts become fictions without adequate ways of seeing "the facts."
R.D. Laing, The Politics of Experience